STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445368	A. BUILDING _____ B. WING _____	C 10/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIMAN CARE & REHAB CENTER	240 HANNAH ROAD HARRIMAN, TN 37748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An on-site visit was made at Harriman Care and Rehab Center to investigate complaints #24861, 25727, 26416, and 26725. No deficiencies were cited for complaints # 26725 and 26416 under 42CFR Part 482.13 Requirements for Long Term Care.	F 000	Harriman Care & Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility investigation report review, and interview, the facility failed to prevent the misappropriation of narcotic medications for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on December 3, 2009, with diagnoses to include Pulmonary Collapse and Open Wound to 4th and 5th Toe of Right Foot. Medical record review of the Minimum Data Set, dated December 23, 2009, revealed the resident was alert and oriented in all areas; had no problems with decision making skills; and experienced moderate pain less than daily.	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administration | (X6) DATE 11/10/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 2 report revealed the Pharmacy had been contacted on December 27, 2009 by LPN #1 who had requested the additional medication, Lortab 5/500 mg, for resident #1. Continued review revealed on December 27, 2009 the pharmacy delivered the controlled substance count sheet and twelve Lortab 5/500 mg for the resident. Continued review revealed LPN #2 worked December 28, 2009 from 2:00 p.m. through 10:00 p.m., and the Lortab 5/500 mg and the controlled substance count sheet for the Lortab 5/500 mg were present. Continued review revealed interviews were conducted and it was determined the Lortab 5/500 mg and the count sheet were present in the medication cart and was last accounted for on December 28 - 29, 2009 at the end of the 10:00 p.m. through 6:00 a.m. shift by LPN #4, who was handing over the keys to the medication cart to LPN #1. Continued review revealed LPN #1 handed over the keys to the medication cart to LPN #5 on December 30, 2009 at the beginning of the 2:00 p.m. through 10:00 p.m. shift. Continued review revealed LPN #5 was interviewed and did not recall the count sheet or Lortab 5/500 mg being present at the beginning of the 2:00 p.m. to 10:00 p.m. shift on December 30, 2009. Continued review revealed LPN #1 worked the 6:00 a.m. through 2:00 p.m. shift on December 30, 2009. Continued review revealed LPN #2, returned to work on December 30, 2009 for the 2:00 p.m. through 10:00 p.m. shift and the 12 Lortabs and the count sheet delivered on December 27, 2010 for resident #1 were missing. Review of the facility investigation revealed on December 31, 2009 LPN #1, #2, #4, and #5 were drug tested. LPN #2, #4 and #5 tested negative for drugs. LPN #1 tested positive for marijuana,	F 224		

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F 224	Continued From page 1 Medical record review of the Physician's Order, dated December 3, 2009, revealed "...Lortab (Hydrocodone-APAP, a codeine based controlled narcotic analgesic) 5/500 mg (5 milligrams codeine and 500 milligrams acetaminophen) 2 tabs (tablets) po (by mouth) q (every) 4 hrs (hours) prn (as needed) for pain..." Medical record review of the Care Plan, dated December 15, 2009, revealed the resident had been identified as being at risk for pain with interventions to include "...prn pain medication..." Medical record review of resident #1's Medication Administration Record (MAR), dated December 3 - 31, 2009, revealed the physician's order for Lortab 5/500 mg remained in effect throughout the month of December. Continued review of the MAR revealed two tabs of Lortab 5/500 mg was documented as administered once each on December 3 and 8, 2009. Review of the controlled substance count sheet (record of number of controlled medications administered and number of controlled medications remaining) for resident #1's Lortab 5/500 mg tablets, dated December 3 - 31, 2009, revealed the resident had 30 doses administered with LPN #1 signing out for 28 of the 30 doses. Review of a facility investigation report, dated December 30, 2009, at 2:15 p.m., revealed the Director of Nursing (DON) was informed by Licensed Practical Nurse (LPN) #2 that a shift count controlled substance (Lortab 5/500 mg) record sheet for resident #1 was missing and the 28 doses of Lortab 5/500 mg was not present. Continued review revealed an investigation began at that time. Continued review of the facility	F 224	**F – 224 Prohibit Mistreatment/neglect/misappropriation of resident property.** **1. Resident #1 was assessed by Director of Nursing and there were no voiced issues of pain or discomfort. The nurse involved was terminated as a result of the investigation findings.** **2. Residents who receive medications have the potential to be affected.** **3. An In-service for all licensed nurses was conducted on 1/14/10 concerning the prevention of misappropriation of resident's property and drug diversion. On 1/15/10 new narcotic sheet count records were implemented. Weekly random audits were completed x 4 weeks. On 1/25/10, 2/1/10, 2/8/10, 2/16/10. There were no negative findings resulting from the audits.** **4. The Audit findings were reported by the DON to the QA committee on 2/17/10. (QA committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD).**	11/15/10

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F 224	Continued From page 3 opiates/morphine, and benzodiazepine. Continued review revealed LPN #1 reported having a prescription for the positive codeine/opiate and benzodiazepine; and admitted to the illegal use of marijuana. Continued review revealed LPN #1 denied ever taking any medication from the facility. Continued review revealed LPN #1 refused to be drug tested at the local hospital and resigned at that time. Review of the facility investigation revealed the facility and the pharmacy consultant did an investigation of patients under the care of LPN #1 to determine if LPN #1 signed out more narcotic medications than might be expected or were out of keeping with the patients' usual dosing of narcotic medications. Continued review revealed LPN #1 did sign out numerous narcotic medications to confused and disoriented residents who, generally, only occasionally required medication for controlling pain. Continued review of the medical records was completed to determine if the residents' experienced unaddressed pain. All residents reviewed did not have documentation to indicate they experience unaddressed pain. Interview by phone with LPN #1 on October 7, 2010 at 2:30 p.m., revealed LPN #1 denied ever taking any medication from the facility. Continued interview revealed LPN#1 had not worked since resigning from the facility. Continued interview with LPN #1 confirmed the positive drug screen results taken by the facility; admitted to smoking marijuana; and related being on prescription medications causing positive results for the codeine/opiate and benzodiazepine. Review of the facility policy, Prevention of Abuse,	F 224		

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F 224	Continued From page 4 Neglect, and Misappropriation of Resident's Property, (no number documented) revised April 2009, revealed "...This facility upholds resident rights and strictly prohibits...misappropriation of resident's property..." Interview in the chaplain's office with the Director of Nursing on September 7, 2010 at 11:00 a.m., confirmed 12 tablets of the controlled narcotic medication Lortab 5/500 mg for resident #1 were missing on December 30, 2009 on the 6:00 a.m. through 2:00 p.m. shift.	F 224		
F 322 SS=D	C/O #24861 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, review of the facility policy "Gastrostomy Feedings #G-3" and review of manufacturer's directions, the facility failed to ensure staff provided appropriate care for a feeding tube for one resident (#4) of seven residents reviewed. Resident #4 was admitted to the facility on December 2, 2008, with diagnoses to include	F 322		

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F 322	Continued From page 5 Late Effect CVA (effects of a stroke) and Dysphagia (difficulty swallowing). Medical record review of the Minimum Data Set, dated August 3, 2010, revealed the resident was alert and oriented only to recent events; had problems with decision making skills; was total assist with all activities of daily living; and was receiving nourishment via jejunostomy (tube used for feeding, surgically inserted into the lower stomach) tube feeding. Medical record review of the Physician's Order's, dated July 21, 2010, no time noted, revealed "... (named tube feeding solution) at 80 ml (milliliters) per hr (hour) ...on 4 (hours), off 2 (hours)...Flush a/ (before) and p/ (after feeding with 30 ml H2O (water)..." Observation with Licensed Practical Nurse (LPN) #4 of the resident in the resident's room on September 7, 2010, at 1:05 p.m., revealed the resident in a semi-seated position in the bed with a tube feeding running via pump at 80 ml/hr. Continued observation revealed, hanging from the tube feeding pump was an 18 inch guide wire in an open plastic sleeve. Continued observation revealed the tip of the guide wire was covered in a crusted yellow substance. Interview with LPN #4 in the resident's room on September 7, 2010, at 1:05 p.m., revealed the guide wire is utilized to "unclog" a feeding tube; the guide wire is reusable; and the tip of the guide wire was covered in a crusted yellow substance. Interview revealed the LPN had not been inserviced on the use of the guide wire to unclog the feeding tube. Interview at the Nurses' Station with the Nurse	F 322	**F–322 NG Treatment/Services-Restorative Eating Skills** **1. The tube feeding declogger was immediately removed from resident #4's room on 9/7/10. Rooms with residents and tube feeding pumps were immediately checked for the presence of opened tube feeding decloggers. The Nurse Practitioner of resident #4 was immediately notified of the situation on 9/7/10.** **2. Residents with tube feedings have the potential to be affected.** **3. An in-service for all licensed nurses was completed on 9/14/10 regarding the instructions for single use tube feeding decloggers. Weekly audits were completed x 4 weeks on 9/13/10, 9/20/10, 9/29/10, 10/4/10. 4. The results of the audits were reported to the QA committee on October 20, 2010. There were no negative findings resulting from the audits. (QA committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD).**	11/15/10

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F 322	Continued From page 6 Practitioner on September 8, 2010, at 4:00 p.m., revealed there had been no symptoms related to the reuse of the guide wire to unclog the feeding tubes in residents receiving tube feedings. Review of facility policy Gastrostomy Feedings, # G-3, revised June 2008, revealed "...To use volumetric infusion pump: 1. Follow the manufacturer's directions for preparing the equipment. 2. After feeding is complete, flush the tube as ordered by physician...5. Clean and store other reusable equipment..." Review of the manufacturer's directions for the (named) guide wire utilized to unclog feeding tubes revealed "...Protocol for use of the (named guide wire)...to maintain patency of gastric and/or jejunostomy enteral tubes...Policy:...The (named guide wire) should be disposed of after a single use..." Interview at the Nurses' Station with LPN #5 on September 7, 2010, at 1:25 p.m., revealed the guide wire used to unclog feeding tubes was reusable and the LPN had not been inserviced on the use of the guide wire. Interview in the Chaplain's office with the Director of Nursing on September 8, 2010, at 1:10 p.m., confirmed guide wires utilized to unclog feeding tubes were not to be re-used and the manufacturer's directions had not been followed. C/O #25727	F 322		